Case History

Date: _____ Email Address (confirmation purposes)_____

Last Name _____ Legal First Name _____ MI _____ Phone (C)_____

Address _____ City _____ ST _____ Zip_____ Phone (H) _____

SS: _____ DOB _____ Employer/Occupation_____ Phone(W)_____

Marital Status _____ Primary Care Physician _____ Health Insurance_____

Gender M F Last Eye Exam/Eye Dr. _____ Vision Insurance _____

Reason for Visit/ Chief Complaint

VISON ___ Fluctuating Vision ___ Blurred Distance ___Blurred Near ___Distorted Vision ___ Double Vision

COMFORT ___ Dry, Sandy, Gritty ___ Burning ___Itching ___ Eye Pain ___Eye Injury ___ Glare or Light Sensitivity

APPEARANCE ___ Eye Turn-In or Out ___ Redness ___ Tired Eyes ___ Discharge ___ Watering ___Droopy eyelid

OTHER _____

Glasses

Do you wear glasses? ___ Yes ___No If you wear glasses please check all that apply below:

I believe my current prescription has changed ___ a little ___somewhat ___ a lot

I am interested in getting new glasses today ___ Yes ___ No ___ Only if my prescription has changed

Contact Lenses

Are you interested in getting contact lenses today? ____Yes ____No Have you worn contacts before? ____Yes ____ No

Brand _____ Solution _____

Comfort of my current lenses is ____ good ____fair ____ poor

Vision with my current contact lenses is ____ good ____fair ____ poor

Past Medical History NONE	**Family Medical History** NONE ____	
___ Diabetes How long? _____ A1C _____	___ Diabetes	Mom / Dad / Brother / Sister / Other
___ High Blood Pressure	___ High Blood Pressure	Mom / Dad / Brother / Sister / Other
___ High Cholesterol	___ Heart Condition	Mom / Dad / Brother / Sister / Other
___ Cancer	___ Blindness	Mom / Dad / Brother / Sister / Other
___ Glaucoma	___ Glaucoma	Mom / Dad / Brother / Sister / Other
___ Macular Degeneration	___ Macular Degeneration	Mom / Dad / Brother / Sister / Other
___ Cataracts	___ Cataracts	Mom / Dad / Brother / Sister / Other
___ Eye Surgery _____	___ Other _____	Mom / Dad / Brother / Sister / Other
___ Other _____		

Please list all medications you are currently taking including eye drops and over-the counters medication: NONE _____

_____

Are you **ALLERGIC TO ANY MEDICATIONS? ____** Yes _____ No (If yes, please list): _____

Do you use tobacco? _____ How often? _____ Do you use alcohol? _____ How often? _____

Current Review of Systems : Do you **CURRENTLY** have any problems in the following areas?

Constitutional:	___NONE Developmental Disability / Fever / Trauma
Ear, Nose, Mouth & Throat:	___ NONE Upper Respiratory Tract Infection
Cardiovascular:	___ NONE Heart Disease / High Blood Pressure / Stroke
Respiratory:	___ NONE Asthma / Bronchitis / Emphysema
Gastrointestinal:	___ NONE Crohn's / Colitis / Ulcer / Digestive
Genitourinary:	___ NONE Urinary Tract Infection / Kidney Ailments
Musculoskeletal:	___ NONE Fibromyalgia / Muscular Dystrophy / Osteoarthritis
Integumentary:	___ NONE Eczema / Rosacea / Psoriasis
Neurological:	___ NONE Multiple Sclerosis / Epilepsy
Psychiatric:	___ NONE Depression / Panic Disorder / Schizophrenia
Endocrine:	___ NONE Thyroid Dysfunction / Hormonal Dysfunction
Hematological / Lymphatic :	___ NONE Anemia / Leukemia
Allergic / Immunological :	___ NONE Seasonal allergy / Lupus / Rheumatoid Arthritis

Are you able to have your eyes dilated today? ____ Yes ____ No (Dilation of your pupils permits thorough evaluation of your eyes, however, effects light sensitivity and in some people blurred near vision that may last for several hours)

Financial Policy and Acknowledgment of Receipt of HIPAA Compliance

All fees for professional services are due the day they are received. We require 50% deposit on any materials the day the order is placed. I authorize the release of my medical information (or my child's) healthcare, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I acknowledge that I have received a copy of HIPAA compliance.

Signatures of Patient or Guardian _____ Date _____ Reviewed by _____